



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

GILBERT MAYORGA MD  
6910 BELLAIRE BLVD SUITE 8  
HOUSTON TX 77074

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-12-3005-01

#### **MFDR Date Received**

MAY 29, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "I am in receipt of recent correspondence sent by Texas Mutual Insurance stating that the modified bills were not received prior to the 95<sup>th</sup> day. We respectively disagree with their findings. Attached please find documentation of delivery of the modified bills prior to the 95<sup>th</sup> day in the form of a green Card/bill which was sent via certified mail which documents the receiving of the modified bill with the corrected CPT code prior to the 95<sup>th</sup> day."

**Amount in Dispute:** \$324.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The requestor billed E/M code 99244 for services provided 6/3/11. Because the code was invalid on the date of service Texas Mutual denied payment. The requestor resubmitted the bill with code 99204. Texas Mutual received this bill 5/22/12. (Attachment 2) Given the change in coding, the bill became a new bill that was untimely. No payment is due."

**Response Submitted by:** Texas Mutual Insurance Co.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2011	CPT Code 99204	\$324.00	\$256.52

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 *Texas Register* 430, sets out the procedure for healthcare providers submitting medical bills.
4. 28 Texas Administrative Code §102.4(h) effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

#### Explanation of benefits

- BAC-B18-This procedure code and modifier were invalid on the date of service.
- 893-This code is invalid or not covered or has been deleted.
- CAC-29-The time limit for filing has expired.
- 731-Per 133.20 provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the service, for services on or after 9/1/05.

#### Issues

1. Does a timely filing issue exist?
2. Is the requestor entitled to reimbursement?

#### Findings

1. The respondent denied reimbursement for CPT code 99204 based upon reason codes “CAC-29 and 731.”

Texas Labor Code §408.027(a) states “A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.”

28 Texas Administrative Code §102.4(h), states “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

(1) the date received, if sent by fax, personal delivery or electronic transmission or,

(2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

The requestor states in the position summary that “Attached please find documentation of delivery of the modified bills prior to the 95<sup>th</sup> day in the form of a green Card/bill which was sent via certified mail which documents the receiving of the modified bill with the corrected CPT code prior to the 95<sup>th</sup> day.”

In support of their position, the requestor submitted a copy of a letter dated July 24, 2011 to the respondent that states in part “Attached please find corrected billing for date of service June 3, 2011. In addition, the requestor submitted a certified green card that was signed and delivered on August 1, 2011. The Division finds that the requestor has supported the position that the corrected bill was submitted within the 95 day timeframe set out in Texas Labor Code §408.027(a). As a result, reimbursement is recommended.

2. CPT code 99204 is defined as “Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.”

Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2011 DWC conversion factor for this service is 54.54.

The Medicare Conversion Factor is 33.9764

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77074, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Houston, Texas.

The Medicare participating amount is \$159.80.

Using the above formula, the Division finds the MAR is \$256.52; this amount is recommended for reimbursement.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$256.52.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$256.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____	10/3/2013
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**